N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Marion

Township: Lyerank
or
Village:
or
City: (NO. St.: Ward)

Registration District No. 1022 File No. 22684-1

Primary Registration District No. 5732 Registered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Harry S. West

PERSONAL AND STATISTICAL PARTICULARS

SEX: mal

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: About (Month) (Day), 1840 (Year)

AGE: About 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): England

PARENTS
NAME OF FATHER: Unk
BIRTHPLACE OF FATHER (City or town, State or foreign country): England
MAIDEN NAME OF MOTHER: Unk
BIRTHPLACE OF MOTHER (City or town, State or foreign country): England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James O. Kepton

(ADDRESS) Stickney Mo.

Filed July 15, 1917. Peter Perry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June 5 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 29, 1917, to June 5, 1917, that I last saw him alive on Apr 29, 1917, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency
(1) 2A

(Duration) 79 yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) M. F. Adams M. D.

June 5, 1917 (Address) Dixon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Oak Grove

DATE OF BURIAL: June 6, 1917

UNDERTAKER: Thos. J. Carr Bro.

ADDRESS: Dixon Mo

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO. ..... , ...St.;.....Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....,

that I last saw h.....alive on.....,191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import